International Journal of Gynecology and Obstetrics 135 (2016) 345–357

Contents lists available at ScienceDirect

International Journal of Gynecology and Obstetrics

journal homepage: www.elsevier.com/locate/ijgo

EVIDENCE FOR ACTION

Strengthening accountability for improved maternal and newborn health: A mapping of studies in Sub-Saharan Africa

Adriane Martin Hilber [a,b,*], Carolyn Blake [a,b], Leah F. Bohle [a,b], Sarah Bandali [c], Esther Agbon [d], Louise Hulton [c]

[a] Swiss Tropical and Public Health Institute, Basel, Switzerland
[b] University of Basel, Basel, Switzerland
[c] Evidence for Action, Options Consultancy Services Ltd, London, UK
[d] Evidence for Action, Options Consultancy Services Ltd, Abuja, Nigeria

ARTICLE INFO

Article history:
Accepted 21 September 2016

Keywords:
Accountability
Advocacy
Evidence for Action (E4A)
Health systems strengthening
Maternal health
Neonatal health
Quality of Care
Sub-Saharan Africa

ABSTRACT

Objective: To describe the types of maternal and newborn health program accountability mechanisms implemented and evaluated in recent years in Sub-Saharan Africa, how these have been implemented, their effectiveness, and future prospects to improve governance and MNH outcomes. *Method:* A structured review selected 38 peer-reviewed papers between 2006 and 2016 in Sub-Saharan Africa to include in the analysis. *Results:* Performance accountability in MNH through maternal and perinatal death surveillance was the most common accountability mechanism used. Political and democratic accountability through advocacy, human rights, and global tracking of progress on indicators achieved greatest results when multiple stakeholders were involved. Financial accountability can be effective but depend on external support. Overall, this review shows that accountability is more effective when clear expectations are backed by social and political advocacy and multistakeholder engagement, and supported by incentives for positive action. *Conclusion:* There are few accountability mechanisms in MNH in Sub-Saharan Africa between decision-makers and those affected by those decisions with both the power and the will to enforce answerability. Increasing accountability depends not only on how mechanisms are enforced but also, on how providers and managers understand accountability.

"Health should be at the center of sustainable development… Accountability will be an important part of the new development agenda."

Ban Ki-Moon, UN Secretary General, May 2014

1. Introduction

"Accountability" has taken the place of "political will" as a silver bullet to improving maternal and newborn health (MNH) in Africa. Like political will, it is a part of a larger construct or health systems thinking that depends on structural, managerial, and financial, as well as power interests (among others) to transform the health sector to deliver better quality of MNH care. Programmatic efforts to increase accountability for MNH as presented in the literature are filtered through a national lens and can only be realized when efforts to measure accountability evolves to include both local and global concepts of transformative change.

Power holders and decision-makers in MNH are increasingly being monitored and held to account through a variety of institutions and processes [1] to meet the challenge of accelerating progress in MNH through the Millennium Development Goals (MDGs) and, since 2015, Sustainable Development Goal (SDG) 3, targets 3.1 and 3.2, with an additional eight targets directly affecting the health and well-being of pregnant women and newborns. As evidence has emerged that maternal and newborn mortality rate reductions are largely not being achieved in Sub-Saharan Africa, or being achieved inequitably, the importance of accountability within health systems, and governance in general, has become a rallying call [2]. Improving MNH quality of care and outcomes is seen as dependent not only on commitments and investments generally, but also increasingly on the strength of accountability for investments in relevant, evidence-based strategies [2]. Although there is a heightened attention to accountability for the delivery of quality services [2,3], there is a lack of systematic study of the various types of accountability in MNH, how they have been operationalized in Sub-Saharan Africa, and the effects of applying different accountability mechanisms in a range of contexts. It has also been argued that accountability as a mechanism (rather than as an organizing principle) focuses on "superficial demonstrations of accountability" including answerability, enforcement, and sanctions between two

* Corresponding author at: Swiss Centre for International Health, Swiss Tropical and Public Health Institute, University of Basel, Socinstrasse 57, P.O. Box, CH-4002, Basel, Switzerland. Tel.: +41 61 284 83 37.
E-mail address: adriane.martinhilber@unibas.ch (A. Martin Hilber).

http://dx.doi.org/10.1016/j.ijgo.2016.09.008

parties, rather than on transformative change of norms that are internal to individuals (providers and clients alike) and institutions—whether supported by policy or not—that can shift power dynamics and create true accountability in the delivery and use of MNH services [4].

For the purpose of this mapping, a conventional definition [5] of accountability is used as reflected in the majority of articles reviewed. Using World Bank nomenclature, the formalized and institutionalized processes that can help to ensure answerability for progress in MNH are defined in this paper as accountability mechanisms. Accountability mechanisms can be political, legal, social, financial, managerial, or professional; formal or informal; and vary in strength depending on the reach of their recourse or sanction processes. Accountability exists when "…an individual or body, and the performance of tasks or functions by that individual or body, are subject to another's oversight, direction or request that they provide information or justification for their actions" [6]. This requires both *answerability* with regards to decisions made, and the possibility of *enforcement* of sanctions or remedy should the power-holder not fulfil its obligations. Accountability can be *diagonal*: when citizens oversee government institutions' actions by engaging in activities such as policy-making, budgeting, and expenditure tracking; *horizontal*: when public officials' actions are overseen by other government agencies; or *vertical*: when public officials are held accountable to citizens, for instance through elections, free press, and an engaged civil society [7]. Public shaming by civil society groups or the media, for example, can also be an effective change agent if those being called to account are dependent on having a positive public image to maintain their power base or position.

Creating accountability to improve MNH outcomes requires involvement of a wide range of actors including civil society organizations (CSOs), government, the health sector, the private sector, media, and the donor community. Accountability mechanisms should be context-specific and address health system as well as socioeconomic, political, and cultural barriers to MNH across the continuum of care [8]. Accountability for MNH, it should be noted, is not inherently rights-based and predicated on the paradigm shift in principles promoted by the International Conference on Population and Development of 1994 and its subsequent review processes and consensus statements of the international community. The context of the application of accountability for improved MNH needs to be negotiated through a political process in which ethics, rights, and functionality of the health system based on shared principles is mutually agreed by all stakeholders in the system for the changes requested to be transformative and sustainable [4]. The growing consensus that accountability can underpin progress was reinforced in the third report of the independent Expert Review Group of the Commission on Information and Accountability for Women's and Children's Health (CoIA) monitoring country progress on the Secretary General's Every Woman, Every Child Strategy. Its six recommendations were to strengthen accountability through greater political support to implement the global plan, "accelerate collective action," engage with civil society, establish results-based financing, and use human rights to monitor progress through the establishment of a Global Commission on Health and Human Rights of women and children [2]. While top down in nature, such global efforts to track and publicize progress against country commitments, targets, and goals set internationally assume public pressure (and shaming) can yield change in the delivery of health services through increased funding, political will, and public support for progress made. "Soft" recourse mechanisms, however, stand in stark contrast to the "hard" sanctions called for in other fields such as climate change where the Montreal Protocol imposed sanctions for noncompliance by States for the phasing-out of ozone depleting substances [9]. Moreover, recourse efforts in MNH remain, until recently in the new SDGs, one-sidedly focused on developing country progress or recipients of aid rather than on the nature, content, and structure of donors and UN organizations' effectiveness in their aid contributions.

In this Evidence for Action (E4A) Accountability Series, accountability mechanisms in MNH have been defined and categorized according to the Brinkerhoff 2001 health systems typology [9] used by WHO and which puts forward three categories of mechanisms: performance, financial, and political/democratic accountability [10]. In many of the mechanisms presented below there is a tension between accountability *for control* (with a tendency for blame) and accountability for improvement, which focuses on learning and incentives [10].

Performance accountability encompasses "public sector management reform, performance measurement and evaluation, and service delivery improvement. Performance accountability refers to demonstrating and accounting for performance in the light of agreed-upon performance targets. Its focus is on services, outputs and results [10]. Based on this broad health systems definition, the following MNH relevant mechanisms are taken into account in this series: maternal and perinatal death reviews; professional norms, standards and bodies; health facility committees; and monitoring and evaluation.

Political/democratic accountability refers to "the relationship between the state and the citizen, discussions of governance, increased citizen participation, equity issues, transparency and openness, responsiveness, and trust-building" [10].

The following MNH mechanisms are taken into account in this series: (1) social accountability-related mechanisms, such as tracking of government commitments in MNH, social audits and complaint mechanisms, petitions, campaigns and protests, and quality of services assessments (scorecards) with community participation; and (2) human rights, which has been increasingly used as a tool for the enforcement in accountability mechanisms: the possibility to avoid the majority of maternal and newborn deaths making it an evident human rights issue [11,12].

Financial accountability deals with "compliance with laws, rules, and regulations regarding financial control and management" [10]. The E4A Series reviews the following MNH accountability mechanisms: (1) financial/budget tracking; (2) performance-based financing; and (3) market dynamics.

This present article describes the types of MNH accountability mechanisms implemented and evaluated in recent years in Sub-Saharan Africa, with a focus on interventions and tools reported in peer-reviewed literature. It provides a conceptual framework to the articles that follow. The structured review sought to answer four research questions: (1) what accountability mechanisms and tools have been put into place to improve the delivery of maternal and newborn healthcare services in Sub-Saharan Africa; (2) how are the accountability mechanisms currently being applied; (3) how effective are these mechanisms; and (4) what are the prospects of future accountability work for improving MNH outcomes in the new 2030 Development Agenda.

2. Materials and methods

The structured mapping of studies focused both on quantitative and qualitative studies filtered by inclusion criteria. A further screening was carried out to select the articles fulfilling a pre-set search criteria.

2.1. Inclusion criteria, search strategy, and screening

The review was limited to peer-reviewed papers published in English, French, or Portuguese between 2006 and 2016 related to the Sub-Saharan Africa region. Only articles that describe an intervention or assess an MNH accountability mechanism or a process used to strengthen such a mechanism were included. The literature search was carried out on February 5, 2016, across five academic data bases: PubMed, Science Direct, Web of Science, IBSS, and JSTOR. The search terms included: "accountability," "maternal health," "neonatal," "newborn," "quality of care," "human right," "governance," "scorecard," "audit," "Sub-Saharan Africa." Further exploration for additional relevant articles was done through selected searches in Google scholar and relevant websites.

The search generated 758 papers that were screened in two stages. The first screening took into account titles and abstracts and the second full text articles. Papers were then subdivided into categories of accountability and grouped by approaches used. Thirty-eight papers were included in total.

Although there were innumerable reports on tracking progress on international development targets and commitments, primarily to the MDGs, ranging from UN reports such as that of the Commission on Information and Accountability (CoIA) for the Secretary General's Every Woman Every Child Global Strategy to nongovernmental efforts such as those of the Institute for Health Metrics and Evaluation (http://www.healthdata.org/), and the Countdown [13], only peer-reviewed papers that described or assessed an MNH accountability mechanism were included. Only one such article [14] was included in this review: an article on the Essential Newborn Action Plan (ENAP). Accountability through other global and regional tracking efforts beyond ENAP is addressed in detail in the paper by ten Hoope-Bender et al. [15] published in this series.

2.2. Analysis

Synthesis of relevant papers included a description and assessment of the accountability mechanisms being implemented in Sub-Saharan Africa in recent years. Specifically we aimed to label the accountability mechanisms used or promoted and their purposes. We also described who was accountable to whom and the consequences for compliance/noncompliance (i.e. what is the recourse mechanism). When possible, we describe the feedback loop that supports improvements as a means to strengthening the quality of the service delivered or change sought. We also assessed whether evidence and advocacy activities (as promoted by the E4A approach) were used to strengthen the accountability mechanism. We then analyzed whether the intervention was evaluated for effect on MNH specifically. The analysis thus provides a structured approach to assessing the evidence on how accountability is used to improve health systems and MNH in particular in Sub-Saharan Africa using the Brinkerhoff 2004 accountability framework definitions, categorized as performance accountability, political/democratic accountability, and financial accountability (see Table 1).

3. Results

The search generated 758 papers, which following screening and allocation to one of the three accountability categories and related mechanisms, resulted in a total of 38 papers: 22 concerning performance accountability, 10 concerning political/democratic accountability, and six concerning financial accountability.

3.1. Performance accountability

Twenty-two articles focused on performance accountability, with a large majority discussing maternal and perinatal death reviews (n = 15). Only five other articles focused on MNH professional organizations and their support for the establishment of norms and standards. Two articles discussed the use of health facility committees to compare the quality of services and facilities through scorecards. Table 1 provides a full overview of the studies.

3.1.1. Maternal and perinatal death and surveillance reviews, audits, and confidential inquiries

The review identified 15 articles presenting findings on the use of various aspects of maternal and perinatal death and surveillance reviews (MDSRs) as a means to call providers, facility managers, and health systems to account for the quality of MNH services provided. The MDSR mechanism, which includes systematic notification of maternal deaths, at facility and community levels, followed by maternal death reviews (MDRs) and verbal autopsies, aims to reinforce actions to be taken to solution identified problems and accountability at all levels. No articles reported on the full MDSR process. Eleven articles reported on government-led efforts to scale up the use of MDRs and audits: two in Tanzania [16,17], one in Botswana [18], and one in Nigeria [19] report on the lack of functionality of the MDR system due to a lack of clarity of processes (Tanzania) and ownership by hospital staff (Tanzania and Botswana), and human resource challenges (Nigeria). In Malawi, a 2008 article [20] discusses the quality improvements gained from combining MDRs and confidential inquiries in maternal deaths (CEMD) while a subsequent study in 2013 [21] documents how implementation of MDRs at community level helped to remove referral barriers and improve the quality of care generally. In Ghana, an article from 2009 [22] notes that the flexible use of CEMD enhanced the conduct of MDRs. This was followed by another study in 2011 [23] that documented initially poor implementation rates of recommendations, when highlighted by social advocacy, led to institutionalization of the audit process, and inspired local leaders and the health services to improve referral. Three studies from South Africa [24–26] documented the establishment of three national committees: one on CEMD, another on perinatal mortality, and a third on child mortality. These three processes oversee MDRs, the review or audit, present recommendations and strategies, and then monitor follow-up. Sustainability is assured by the government.

Project-based support for MDRs and audits was documented in two time intervals by Dumont et al. [27] in Senegal. In 2006, support for the District maternity to conduct the process over time resulted in improvements in the organization of care with a marked effect on lifesaving interventions [27]. In the subsequent study in 2009, support for facilities and administrators extended to providers. While most health professionals were receptive of the process, some felt the process "destabilizing and even threatening" [28].

Two articles reported on *community engagement in MDRs* and audits to detect maternal deaths in real-time and uncovered clinical and social factors contributing to mortality, adding another layer of accountability by local stakeholders for the quality of care received (or not received). A routine community-level surveillance system by community health workers supported by mobile health (mHealth) technology in Senegal identified barriers and inefficiencies in hospital care and sped up the data collection, review, and action cycle for greater accountability and improvement in the quality of care [29]. A community-linked maternal death review process in Malawi involving community verbal autopsy, community and facility review meetings [30], and, in Mali and Senegal [31], community and facility reviews, were implemented with external support; both report improvements in the quality of care.

3.1.2. Professional organizations

In total, five articles discussed the role of professional associations in increasing accountability for the quality of MNH care, of which only one [32] used regulatory mechanisms such as professional norms and standards to call providers to account for the quality of the services they provide in MNH. A FIGO-supported initiative in Uganda aimed to build the capacity of professional organizations to influence policy to improve MNH services [33]. The same FIGO-supported initiative was also carried out in Cameroon [34] and Ethiopia [35], where facility quality improvements were also reported. The Society of Obstetricians and Gynaecologists of Canada's (SOGC's) ALARM program also provided technical training and support for implementation in Mali and Senegal in partnership with the national obstetric and gynecology societies that improved the quality of care at admission and postpartum monitoring [31]. In Kenya, the professional society used professional norms to improve the quality of MNH care through a normative re-educative intervention to reset norms and values concerning good practice and promoted "grass-roots" participation to improve delivery of quality MNH care. Through this strategy they created "a soft contract" with senior managers clarifying roles and expectations around desired performance

Table 1
Accountability mechanisms, definitions, and selected articles from Sub-Saharan Africa.

Type	Accountability mechanisms	Definition	Approaches	Articles/reference number	Location
Performance accountability	**Maternal and perinatal death and surveillance reviews, audits and confidential enquiries of maternal death**	Facility-based maternal death and surveillance review (MDSR) including maternal death reviews (MDRs), audits, and confidential enquiry of maternal death (CEMD) (at national level) usually supported by health managers at district, region/province, and national level, aim to identify avoidable factors and opportunities for improvement through a confidential multidisciplinary team discussion with contributions from staff involved in the patient's care and a review of the patient documentation (Beyond the Numbers, WHO 2004).	*National MDSR and CEMD (n=11)*	Nyamtema et al. 2010 [16] Armstrong et al. 2014 [17] Mogobe et al. 2007 [18] Kongnyuy et al. 2008 [20] Vink et al. 2013 [21] Hussein et al. 2009 [22] Issah et al. 2011 [23] Hofman & Mohammed 2014 [19] SA Every Death Counts Writing Group 2008 [24] Rhoda et al. 2014 [25] Belizán et al. 2011 [26]	Tanzania Botswana Malawi Ghana Nigeria South Africa (SA)
		Project-based maternal death reviews and audits support a district or facility to conduct the process for a period of time with external support.	*Project-based MDR and audits (n=2)*	Dumont et al. 2006 [27] Dumont et al. 2009 [28]	Senegal
		Community engagement in MDRs can support maternal death notifications and uncover clinical and socioeconomic factors contributing to mortality.	*Community-based MDR (n=2)*	Bayley et al. 2015 [30] Moshabela et al. 2015 [29]	Malawi Senegal
	Professional organizations	FIGO and national maternal and newborn-related professional societies strengthen performance accountability by developing clinical training programs, and by engaging with civil society and government for increased support, recognition, and resource allocation for MNH.	*Capacity building and advocacy (n=4)*	De Brouwere et al. 2014 [34] Beyeza-Kashesya et al. 2014 [33] Gebrehiwot et al. 2014 [35] Pirkle et al. 2013 [31]	Cameroon Uganda Ethiopia Mali, Senegal
		Performance accountability by strengthening norms and standards in clinical practice and by creating a culture of "good practice" among professionals.	*Normative mechanisms (n=1)*	English et al. 2011 [32]	Kenya
	Assessment tools or scorecards	Performance can also be strengthened through regular facility assessments that involve a multistakeholder team using set criteria, which are then translated into a scorecard per facility for making comparison and healthy competition or "benchmarking" between facilities. Clinical outcome data can also be used for comparison between facilities and presented in popular formats for clients and providers.	*Assessment tools including scorecards to monitor progress (n=2)*	Yilla et al. 2014 [37] Crofts et al. 2014 [36]	Sierra Leone Zimbabwe
Political and democratic accountability	**Social accountability**	Democratic accountability is attained through civil society campaigns that aim to increase political and social pressure for improvements in MNH; This can be attained through the engagement of community members within formal service delivery and quality improvement systems.	*Community engagement and CSO advocacy (n=3)*	Ray et al. 2012 [38] Mafuta et al. 2015 [39]	SA, Botswana, Kenya Uganda Democratic Republic of Congo (DRC)
		Nationally established commissions/platforms provide accountability to citizens on the enforcement of laws, polices, strategies, or commitments to rule on abuse, and track progress on MNH commitments and action plans. While not legally binding, they provide social and political impetus for action by ministries of health, finance, and others.	*National Accountability Mechanisms (n=2)*	O'Meara et al. 2011 [40] Center for Reproductive Rights; Federation of Women Lawyers, 2007 [41] Garba et al.2014 [42]	Kenya Kenya Nigeria

	Political accountability	The UN and other international development partners (including journals such as the *Lancet*) monitor progress toward attainment of the MDGs and now the SDGs and their implementation. Recently, renewed commitments to saving newborn lives and preventing stillbirths have been made by many governments and partners in response to the UN Secretary-General's *Global Strategy for Women's and Children's Health* and its accompanying *Every Woman Every Child* initiative, committing to recommendations made by the Commission on Information and Accountability for Women's and Children's Health. Relevant action plans have been developed including the *Every Newborn Action Plan* and endorsed by stakeholders to increase national efforts for newborn survival.	*Country progress and national level monitoring n =(1)*	Kinny et al. 2015 [14]	Global (including regional Sub-Saharan Africa (SSA) data)
	Human Rights	The international human rights system through its Universal Periodic Review (UPR) requires signatory States to report on progress made toward ensuring improvements in MNH care (under their obligations to respect, protect, and fulfill the rights to health). In Africa, the African Court of Justice and Human Rights is supported by the African Commission on Human and People's Rights. As in the UPR, national governments are to report periodically to the African Commission offering a regional human rights accountability platform.	*United Nations Human Rights System (n =1)*	Balogun and Durojaye, 2011 [43]	SSA
		National advocacy campaigns and social movements engage with the national legal systems to hold their government to account.	*National legal recourse mechanisms (n =1)*	Jones, 2005 [46]	South Africa
		Project and tools with a human rights-based approach have been developed to operationalize State obligations (based on the treaties and conventions they have ratified) to respect, protect, and fulfill their human rights requirements related to maternal and newborn health. A human rights-based approach is a conceptual framework that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights.	*Human Rights Based Approach (n =2)*	Mhango et al. 2013 [47] Cottingham et al. 2010 [11]	Malawi Mozambique
Financial accountability	**Financial and budget tracking schemes**	Tracking of official development assistance for MNCH is carried out to promote accountability among donors, in line with the Abuja and Paris agreements by donors. This is done in conjunction with national governments.	*Global tracking (n =1)*	Powell-Jackson et al. 2006 [48]	SSA and global
		Tracking of budget allocations and expenditures is carried out through monitoring of national health subaccounts, and specifically RMNCH subaccounts to facilitate ministries and civil society to track promised budget allocations and expenditures.	*National health subaccounts (n =2)*	Sidze et al. 2013 [49] Mbeeli et al. 2011 [50]	Kenya Namibia
	Performance-based payment schemes	Performance Based Financing (PBF) is a results-oriented approach that incentivizes providers based on their achievement of agreed-upon, measurable performance targets.	*Performance based financing (health worker level) (n =2)*	Basinga et al. 2011 [51] Sipsma et al. 2012 [67]	Rwanda Rwanda
		Demand-side financing through consumer-led (vouchers, cash transfers, tax rebates) or provider-led (capitation payment, referral vouchers) approaches incentivize utilization of services and or efficiency in service delivery through competition	*Vouchers (n =1)*	Bellows et al. 2013 [52]	Kenya, Uganda and Sierra Leone

that led to improvements in leadership, accountability, and resource allocation [32].

3.1.3. Scorecards and assessments to monitor progress through health facility committees

Two articles reported on the use of health facility data made available through scorecards and other visual formats to improve the quality of MNH care by engaging health facility committees, providers, and communities. Adaptation and implementation of local maternity dashboards in a Zimbabwean hospital helped to drive clinical improvement [36], while in Sierra Leone, data from facility assessments monitoring implementation of the Sierra Leone Free Health Care Initiative of 2010 presented as facility scorecards contributed to facility-level improvements for MNH [37].

3.2. Political and democratic accountability

A total of 10 papers were found that documented social or political accountability mechanisms related to MNH: 3 articles focused on community engagement and CSO advocacy; 2 on the use of national laws and policies; 1 on monitoring of country level progress against international targets; and 4 on the use of Human Rights instruments to influence governments to act on their commitments.

3.2.1. Social accountability

In total, five articles discussed social accountability mechanisms in MNH: three focused on engagement of civil society including clients, professional associations, political activists in their call for social and political accountability from government ministries on their public commitments; and two demonstrated the use of laws, policies, and regulations as national accountability mechanisms [38–42].

Three articles report on community and CSO engagement in social accountability efforts to improve MNH. One article reported on how partnerships between CSOs and professional associations in advocacy to strengthen health systems were used in four country contexts (South Africa, Botswana, Kenya, and Uganda) to reduce maternal mortality. Using the successful South African Treatment Action Campaign model (http://www.tac.org.za/), these civil society partnerships used a complement of social accountability mechanisms such as the use of CEMD, shadow reports to UN Human Rights Treaty Monitoring Bodies, and litigation to put pressure on the government to act on recommendations received from the international human rights committees [38].

Two articles presented the role of communities in improving the quality of services and accountability of health providers and local government. In Kenya, community participation through health facility committees created a formal level of engagement in district level planning placing them in a better position to ask for accountability or rather answerability from decision-makers at district level [40], while in the Democratic Republic of Congo (DRC) [39] community participation in local government processes to improve MNH services was facilitated but done so in an *ad hoc* manner. In both cases, the lack of defined institutional accountability processes in case of noncompliance (e.g. by the health center and managers at district level) limited the opportunity to voice discontent. Neither paper mentioned the use of advocacy-related activities to strengthen the accountability mechanism. The need for evidence in strengthening the accountability mechanism is mentioned; in the DRC, community members were not given access to data on MNH services, however in Kenya, community members produced data on their local health issues and priorities.

Social accountability through national-level social accountability mechanisms supported by laws, policies, or regulations was reported in two articles. In Nigeria, an Independent Accountability Mechanism (NIAM) run by an independent civil-society led Expert Review Group (iERG) was established to track MNH commitments and actions plans. NIAM members that include elected representatives from civil society, media, and health professional bodies demanded accountability from the central government and monitored actions resulting from their demands. As yet, it is unclear what recourse mechanism exists in case of noncompliance; however, the use of evidence and advocacy to strengthen the accountability mechanism is well supported [42]. In Kenya, with the support of international and national human rights organizations, advocacy around poor quality of care succeeded in getting the government to remove user fees for maternity services in all public health institutions and secure the appointment of a new head of the maternity hospital by someone experienced in a reproductive rights approach to maternal health. This project was innovative in that the midwives' association, together with human rights organizations provided rights-based training to service delivery, and secured support from the office of the Director of Public Prosecutions to help prosecute cases involving abuse in MNH services. In response to the report by the groups, the Kenya National Commission on Human Rights began a Public National Inquiry on Sexual and Reproductive Health in June 2011 involving country-wide public hearings, testimonials, and expert forums [41]. None of the three papers presented mechanisms that were assessed for MNH-related impact.

3.2.2. Political accountability: country progress and national-level monitoring

One paper discussed political accountability mechanisms in MNH [14] and focused on country progress toward implementing the UN Every Newborn Action Plan (ENAP) initiative, including many Sub-Saharan Africa countries. Launched in 2014, ENAP aimed to achieve equitable coverage of high-quality care for all women and newborns through links with other global and national plans and measurement and accountability frameworks [14]. Although ENAP was endorsed by World Health Assembly resolution WHA 67.19, which recommended countries implement, monitor, and report on commitments, there is no mention of who can demand accountability, where answerability lies for country progress, and which recourse mechanisms exist at country, regional, and international level. Such global action plans and their tracking stimulate political accountability, but there is no documented recourse mechanism for inaction or related impact on MNH.

3.2.3. Human rights

Human rights as an accountability mechanism includes the use of human rights commitments (through ratification of human rights treaties and conventions) as a tool of enforcement to respect, protect, and fulfil legal obligations related to MNH. While there were many articles that discussed human rights-based approaches to MNH, only four provided clear examples of the use of human rights as a means for accountability for MNH care in Sub-Saharan Africa. One article provided a review of how the UN Human Rights System was used to call State actors to account for maternal, child, and newborn health in the region. One article [43], reviewed the work of the African Commission for Human Rights and the implementation of the African Women's Protocol, which specifically outlines the Right to Health of Women related to pregnancy and childbirth. It noted that unlike in Latin America, where there was a case where the CEDAW committee ruled that the failure of a State to provide emergency obstetric care for a pregnant woman amounts to violations of the rights [44], the African Commission and the Women's protocol is "not yet fully implemented due to lack of State recognition and enforcement of Human Rights standards in the region."

Another article also used national legal recourse mechanisms to enforce State human rights obligations enshrined in the constitution to access to lifesaving medication for prevention of mother-to-child transmission of HIV. The Treatment Action Campaign (TAC) in South Africa won a legal suit in the constitutional court to expand access to nevirapine despite regulatory and financial barriers cited by the government. The court stated that it is the obligation of the State "to devise and implement a more comprehensive policy that will give access to health care services to HIV-positive mothers and their newborn children, and include the administration of nevirapine where that is appropriate.

Policy, as reformulated, must meet the constitutional requirement of providing reasonable measures within available resources for the progressive realization of the rights of such women and newborn children" [45,p. 68]. The TAC approach, however, uses social litigation as a key tool in its social and political campaign work through its mass base to take aim at the formal political channels available in South Africa [46].

Two papers used WHO Human Rights Based Approach (HRBA) as a process to review national laws and policies related to MNH: one for Community Based Integrated Management of Childhood Illness (CB-IMCI) in Malawi [47], and the other in Mozambique [11]. In both cases, WHO facilitated use of the process by multisectoral government workers to review policy, and in the case of the CB-IMCI with other partners begin a community discussion to develop a human rights-based approach to policy, planning, and implementation. While the use of such processes has no formal recourse mechanism, they did achieve changes in policy, and approaches by the Ministry of Health. In Mozambique, the review identified critical barriers and informed the development of the integrated maternal, neonatal, and child health package of care. In Malawi, use of the CB-IMCI process pushed the government to systematically include an HRBA in policy-making by including rights in their MCH and child survival strategic plans and strategies since 2005/2006, when the IMCI strategy was introduced.

3.3. Financial accountability

Six papers reported on the use of financial mechanisms for accountability usually as a safeguard against inefficiency, misuse of funds, and corruption to secure quality MNH services.

3.3.1. Financial and budget tracking mechanisms

Three articles dealt with financial and budget tracking mechanisms including the allocation of resources between 2006 and 2014 [48–50]. One article reported on global tracking of official development assistance for MNCH to promote accountability among donors [48]. Two articles focused on national health subaccounts and resource allocation by governments and donors and expenditures in Kenya [49] and Namibia [50]. The need for (aggregated) data of higher quality in Kenya was reported [49], whereas the request to examine critically the efficiency in the allocation and use of reproductive health expenditures was raised in Namibia [50]. One article recommended the inclusion of NGOs and development partners into national health account teams [49]. All three papers were limited to recommendations and did not provide information on the recourse effect related to accountability.

3.3.2. Performance-based payment schemes

Two papers focused on performance-based financing related to MNH between 2011 and 2013. Two articles from Rwanda measured the effect of performance-based payment for healthcare workers on the quality of care [23] and the effect on the use of MCH services [51]. The two studies presented opposite results on whether the outcome of the studies led to greater accountability. One study focused on maternal health voucher programs in 28 countries including Kenya, Uganda, and Sierra Leone [52]. They found commonalities in the design of such programs and that such modalities can serve as a demand creation instrument as they contain an inherent accountability mechanism in that the voucher is the "payment" for the desired action. It is unclear whether vouchers contribute to greater accountability in the system beyond the set desired outcome however.

4. Discussion

Global, regional, and national efforts that call for greater accountability from governments, health managers, and providers for the delivery of quality MNH services are increasingly promoted (as shown in this review), yet the coverage remains low and their effect to date has been mixed with few approaches able to document sustainable change. Progress has been most pronounced where recourse or punitive measures support enforcement of rules, regulations, norms or practice, and is made public through social and political advocacy. Multistakeholder and multi-tactic approaches that target not only specific problems (i.e. access to treatment) but also the underling norms around inequality in access to care (as done in South Africa by the Treatment Action Campaign) have had the greatest impact. Government-established national commissions to review all MNCH deaths, supported by national advocacy campaigns and social accountability processes, and reinforced by litigation are a strong example of effective accountability in practice in the region [24–26,46]. Acting across several sectors, as South Africa demonstrated, was also effective in Botswana, Kenya, and Uganda [38] where activists and media enhanced their capacity to act by building awareness around the results of confidential enquiries and the recommendations of the Human Rights Treaty Monitoring Bodies.

Multi-actor and multi-tactic approaches, however, are few. Table 2 summarizes the facilitators and barriers to implementation of specific recourse mechanisms. The most common approach is the use of various approaches to maternal and perinatal death surveillance as an accountability intervention to monitor performance of providers and facilities. MDSRs are increasingly regarded as "best practice" to address provider and health system weakness or failure, yet as shown in this review and others, effective coverage is low without substantial project-related support and mentoring for the intervention [53]. Successful implementation depends upon government leadership, engagement of district managers and providers, flexibility in approach to implementation, and critically the institutionalization of the process to create collective ownership and response. Making maternal death notifiable by law adds to accountability. Weakness of existing systems and resource constraints limit institutional ownership. The onus then falls on individual senior managers or providers, which limits the level of support for follow-up, and potentially focuses problems on individuals rather than the broader context of organization and delivery of care.

Accountability through standard regulatory mechanisms as traditionally done by professional organizations in low-resource countries also facilitates the implementation of MDSRs, CEMD, and audits. Medical misconduct, for example, when regulated, monitored, and controlled through disciplinary action is perhaps one of the most developed examples of accountability for quality services despite WHO's Beyond the Numbers guidance that advocates "no name, no blame," which assumes that mismanagement is a team issue to be solved while maintaining anonymous processes [54,55]. Monitoring of performance and answerability through MDSRs, professional standards, and health system oversight by government are key factors that reduced maternal mortality in recent years, as in the case of Sri Lanka [56] and Rwanda [57]. High-resource country professional associations are playing an important role in supporting the development of societies in lower resourced countries through project partnership, training, advocacy, and external supportive supervision. Efforts such as FIGO's Leadership in Obstetrics and Gynecology for Impact and Change (LOGIC) initiative in MNH and SOGC's ALARM program have been effective in improving quality of care, raising awareness, and gaining media attention to MNH but are limited by project resources that cannot be sustained over time. For professional societies to play a leading role, they need to partner with government to better regulate and motivate providers to improve the quality of care they deliver.

Performance monitoring through nonbinding assessments on the status of facilities and services presented as scorecards, or other visual formats [58], supported by a participatory, multistakeholder process can provide the information and evidence needed for managers and providers to make evidence-based decisions to improve the quality of MNH care. Data alone, however, may not be sufficient if not transparent or of sufficient quality. In addition, such approaches are often fragile as the answerability for poor performance is either unclear or unenforced.

Social and political accountability was most effective when advocacy increased in support of other more binding mechanisms such as

Table 2
Recourse mechanisms, facilitators, and barriers to MNH accountability found within selected articles.

Type	Accountability mechanism and approaches	Recourse mechanism[a]	Facilitators to effective accountability	Barriers to effective accountability
Performance accountability	**Maternal and perinatal death and surveillance reviews including audits, and confidential enquiries of maternal death.** • National MDR and Confidential Inquiries • Project-based MDR and audits • Community-based MDR	• Health system managerial professional disciplinary action (++) • Legal redress for medical malpractice (++) • Negative publicity and threat of legal action (+) • Community support and or discontent and social reprisal for non-action (-)	• Government leadership and ownership strengthens accountability within the health sector and assures sustainability [24–26]. • Engagement of district hospitals improves organization and quality of care [27]. • Flexible use of Confidential Enquiries of Maternal Deaths encourages use and conduct of MDRs including CEMD and audits [22]. • Combining MDRs and criteria-based audit improves quality and utilization (but not availability) of EmONC [20]. • Institutionalizing audits supported by communities (through advocacy) strengthens collective ownership, responsibility (for referral, removal or transport and other social barriers) and quality of care [5,7,9]. • National review of MDRs can make maternal death notifiable by law [18]. • Community involvement in MDRs and audits can detect maternal deaths quickly and uncover clinical and social factors contributing to mortality [30]. • Routine community-level surveillance system (supported by Mobile Health technology) and MDR with verbal autopsy, community and facility review meetings improves reporting, and more corrective action is taken especially when done with community feedback meetings to maintain interest and support [29,30].	• Poorly functioning systems within a weak health system limits effectiveness [16–18,23]. • Poorly functioning facility-based committees create lack of ownership focused on individuals rather than cadres of health workers [18]. • Facility-based MDRs are often undermined by human resource challenges [19]. • Problems identified by MDRs and CEMDs are not followed up demotivating staff to maintain a functioning system [17]. • Health professionals and service administrators feel threatened by the process [28].
	Professional organizations • Capacity building and advocacy • Normative mechanisms	• Professional ethics creates pressure for improvement in quality of care (+) • Health system managerial professional disciplinary action (++)	• Professional association partnerships (between associations from more developed and less developed countries) strengthen the developing country associations to play a larger role to oversee and improve the quality of care of their providers [33–35]. • Professional organizations provide training and advocacy to update norms and standards and create a culture of "good practice" among professionals [32,35]. • External supportive supervision can create an agreement or soft contract with senior managers clarifies roles, expectations, leadership, accountability, and resource allocation to enhance workers' commitment, capacity, and improved clinical care [32].	• Following guideline development, no follow-up is done due to lack of resources and motivation by hospital teams [34].
	Assessment Tools • Assessments of scorecards to monitor progress • Health facility assessments	• Health system managerial professional corrective action (+) • Professional ethics creates normative pressure for improvement in quality of care (+) • Community support and or discontent and social reprisal for non-action (-) • Negative publicity for non-performing facilities (-)	• Use of Assessments or scorecards to create a participatory, multistakeholder platform to monitor progress at facility level [36,37]. • Assessments of scorecards provide information to evaluate and act on facility readiness to improve quality of care, and facilitate informed, decision-making [36,37]. • Implementation of maternity assessment called "dashboards" with clinical outcome data using common computer software supports rapid identification of adverse trends and suggestions for actions to improve healthcare quality [36]. • Presentation of scorecards evidence for providers in visually engaging formats increases decision-making for facility based improvements [37]. • Scorecards facilitate communication, strengthen coordination, and create healthy competition among facilities, communities, and district level authorities [37].	• Transparency of data on the status of services and facilities can result in frustration and be demotivating if no action is taken for improvement [36]. • Sustaining momentum if no further training, resources, or supportive supervision is provided following poor results can be an issue [37].

Political and democratic accountability	**Social accountability** • Community engagement and Civil Society advocacy • National Accountability Mechanisms	• Community support and/or discontent and social reprisal for non-action (-) • Negative publicity and threat of legal action (+) • Health system managerial professional disciplinary action (++) • Professional ethics creates normative pressure for improvement in quality of care (+) • Legal action (++)	• Building coalitions of community stakeholders and others such as patient groups, professional associations, human rights activists, media, and others increases political and social pressure for improvements in MNH [32,38,40,41,46]. • Social action campaigns that combine tactics such as social mobilization, litigation, NGO "shadow reports" to the UN Human Rights Committees, confidential inquiries, scorecards with community participation to mount political pressure to act on recommendations for improvements or perceived obligations of the state of health service [33,32,38,40,41,46]. • Strengthening the capacity of activists and the media on how to use human rights-based advocacy builds awareness of problems and supports engagement and mobilization [33,38,41,42]. • Community participation in health facility committees are formally and actively engaged in the accountability process and better positioned to seek answerability at district and provincial level [40]. • Nationally established commissions strengthen accountability to citizens on the enforcement of laws, polices, strategies, or commitments [41,46]. • Multisectoral independent expert review groups rule on abuse, and track progress on MNH commitments and actions plans providing social and political impetus for action [38,41,42,46].	• Maternal and newborn health has not received sustained coverage as a social issue [38]. • Women rarely voice their concerns and expectations about health services due to: the absence of procedures to express them, to the lack of knowledge, fear of reprisals, among other social norms limiting engagement [39]. • Feedback systems from decision-makers to community members often are not responsive or functional [40]. • Lack of oversight mechanisms limit space for voicing discontent or building coalitions despite the many local associations and groups. Structures for discussion and claiming rights are relatively absent in most contexts [39,43].
	Political accountability • Country progress and national level monitoring	• International public shaming (+) • Reduced donor funding for poor performance and commitment (+) • Negative publicity (+) Community support and or discontent and social reprisal for non-action (-)	• ENAP implementation in 18 high-burden countries inspired concrete action to advance the newborn health including the inclusion of a newborn mortality target [14]. • Global stocktaking following international commitments related to the Secretary General's Global Strategy: Every Woman Every Child and its accompanying Commission on Information and Accountability (CoIA) was advanced with the development of ENAP, which helped to link global and national plans, measurement, and accountability frameworks [14]. • The ENAP implementation in countries is well-supported by UN and multilateral and bilateral agencies resulting in new, substantial financial commitments [14].	• Despite additional financial support, tracking of national funding remains a challenge [14]. • For interventions with strong evidence, low levels of coverage persists and health information systems require investment and support to improve quality and quantity of data to guide and track progress [14].
	Human rights • United Nations human rights system • National legal recourse mechanisms • Human rights-based approach	• Universal Periodic Review (UPR) calls States to account for their international human rights commitments and obligations related to MNH (++) • International public shaming (+) • Reduced donor funding for poor performance and commitment (+) • Legal action (State human rights commitments must be reflected in National laws) (++) • Negative publicity (+) • Community support and or discontent and social reprisal for non-action reported in shadow reports to the UPR (+)	• The human rights system and its reporting structures through the UPR are a State-driven process, under the auspices of the Human Rights Council, and provide the opportunity for each State to declare what actions they have taken to improve the human rights situations of mothers and children in their countries and to fulfill their human rights obligations [43]. • The African Court of Justice and Human Rights and the African Women's Protocol has specific provisions on the rights of women and girls related to maternal health and can be a powerful accountability mechanism to ensure governments respect, protect, and fulfill their human rights obligations related to MNH [43]. • Human rights-based processes prompt public awareness and heighten attention to human of mothers and children [11,38,47]. • Human rights structures provide an opportunity for civil society to hold governments to account for human rights commitments and promises made related to MNH [11,38,43,46,47]. • Recognition of, and use of human rights commitments for social advocacy, legal recourse (national laws should be in accord with national human rights commitments), and political pressure have been effective, when done strategically, to advance health issues, particularly in the HIV domain [38,46].	• The African Court of Justice and Human Rights and the African Women's protocol is not yet fully implemented due to lack of State recognition and enforcement of Human Rights standards [43]. • The African Commission urges that maternal mortality should be declared a state of emergency yet significant success cannot be achieved when African governments are not fully engaging with the human rights system [43]. • Use of human rights and legal resources at national level requires a functioning judiciary to uphold State laws [11,43,46,47].

(continued on next page)

Table 2 (*continued*)

Type	Accountability mechanism and approaches	Recourse mechanism[a]	Facilitators to effective accountability	Barriers to effective accountability
Financial accountability	**Financial and budget tracking schemes** • Global tracking • National tracking and health subaccounts	• International public shaming (+) • Reduced donor funding for poor performance and commitment (+) • Negative publicity (+) • Community support and or discontent and social reprisal for nonaction (-) • Awareness raising about actual expenditures versus budgets leads to social accountability (+)	• Tracking of overseas development assistance (ODA) in 150 countries showed a positive association between ODA and mortality reduction (though with great variation between countries) [48]. • Donor fund tracking makes it possible to hold donors to account for their ODA expenditure [48]. • The Reproductive Health Tool of WHO is available to support tracking of reproductive health subaccounts. [49,50]. • Budget tracking of allocations and expenditures through national health subaccount, and specifically RMNCH subaccounts allows ministries and civil society to track promised budget allocations and expenditures. [49,50]. • The resource flow project supported 22 countries in SSA to complete at least one round of budget tracking using the Reproductive Health Account tool [49]. • The process of creating subaccounts heightens interest in critically examining the efficiency of allocations leading to increased use of reproductive health expenditures [50].	• National efforts to track subaccounts require aggregated data of higher quality, which may not be available. Including NGOs and development partners into national health account teams can improve data availability [49,50].
	Performance-based payment schemes • Performance-based financing (PBF) (health worker/facility level) • Vouchers	• Payment and social recognition for performance (++) • Community support and or discontent and social reprisal for nonaction (-)	• Financial and social recognition and incentives improve performance of providers and health facility managers [51]. • Performance for payment scheme for healthcare workers improved the quality of care, and the use of MCH services [51]. • PBF can increase the use and quality of healthcare services, stabilize or decrease the cost of these services, support the effective use of limited resources, and improve staff motivation, morale, and retention [67]. • Maternal health voucher programs in 28 countries showed commonalities in design including reliance on external contracting to private providers, or third-party management agencies, strong community mobilization, and targeting of individuals with national level impact [52].	• Improvements were aligned with the amount of the payment and inversely proportionate to the amount of work required by the health worker [67,51]. • Despite training for improvement in performance and receipt of provider-based incentives through PBF, no evidence that training supervision or incentives improved use of recommended practices [67]. • It is unclear whether vouchers contribute to greater accountability in the system beyond the set desired outcome however [52].

[a] Strength of recourse mechanism:
Unknown (-): Recourse is not established; cannot be attributed to the accountability mechanism.
Soft (+): Accountability is not formal and thus not enforceable; works through accepted political, social, cultural, or professional norms to call those implicated to account for failure to act, allocate, or implement recognized obligations or duties.
Hard (++): Accountability mechanism includes a feedback loop with established, approved answerability or punitive action; actors engaged are aware of obligations and consequences (usually through legal, statutory, or professional regulations).

implementation of laws, policies, or international human rights obligations by creating public pressure on decision-makers to act on identified problems. Using civil society stakeholders raises awareness but does not necessarily create the desired improvements in the quality of care as they do not link directly to consequences of inaction, or to power structures that largely dictate whether and how change happens [4]. Building the capacity of coalition partners including the media (particularly through facility committees, commissions, or expert review groups) supports accountability by better positioning stakeholders to seek answerability. Low level of attention to MNH issues and the economic and gender-based power structures that limit voicing of discontent, respect for participation, and the lack of structures for claiming rights and enforcement of established norms and rules are also barriers to advocacy; however, some can be partly overcome through multistakeholder approaches.

Despite the challenges, landmark documents by WHO [59], the Commission on the Social Determinants of Health [60], and the World Bank position paper on "social accountability," or "citizen-led accountability" all emphasize the role of social and political accountability as a key approach to improved health, development, and governance [61]. Global initiatives such CoIA set up to monitor progress in implementation of the UN Secretary General's Global Strategy for Every Woman, Every Child [62] (and now the Global Strategy 2.0 related to the SDGs) [63] also clearly advocate for greater accountability through social and political advocacy and monitoring of performance indicators [59]. In this review, implementation of ENAP, facilitated and backed by international and local partners, inspired action, particularly when linked to financing for national strategies, and accountability frameworks for programming around the newborn. While global strategies and action plans clearly help focus national efforts and stimulate external resources, as yet there is insufficient information to say whether such international advocacy affects which intervention strategies are taken up, how they are sustained, and their ultimate effectiveness. Similarly, human rights approaches are heavily supported internationally through State driven processes such as the Universal Periodic Review (of State's Human Rights obligations). Grounded in regional human rights institutions and protocols, they have the potential to be effective but as yet remain aspirational because of the lack of juridical oversight and respect for global human rights instruments (such as international courts) [62].

Some see financial accountability [64,65] as an achievable solution to poor results in the health sector [62,63] as it is intrinsically a control mechanism, especially if implemented with transparency and clear objectives [66]. For African countries, tracking of overseas development assistance by donors adds impetus to hold high-resource countries to account for promises made at Abuja and through the SDGs [48]. However, when reflecting on whether greater accountability was achieved within the healthcare system as a result of the performance-based payments or voucher systems, evidence is mixed and hotly debated [51,67–69]. Synthesis of systematic reviews found limited evidence on whether pay-for-performance could help to achieve the MDGs because the incentive targeted patients and providers individually and thus produced only a short-term, individually-based effect rather than a consequential change in use of MNH services or professionalism by providers for better quality of care.

4.1. Accountability versus political will

This review shows that accountability, whether local, national, or international is more effective (particularly in the immediate term) when clear expectations are backed by social and political advocacy, and supported by incentives for positive action (e.g. performance, financial, social, or political recognition and reward). "Soft" recourse threats of consequence (such as political shaming through the media, or at the ballot box), rather than "hard" recourse measures (such as litigation, appealing to international monitoring (e.g. the SDGs) and arbitration bodies such as the UPR for human rights obligations [62]) dominate accountability efforts to date. And, perhaps as a result, despite decades of campaigning for safe motherhood, skilled attendance, maternal and child mortality reductions, reproductive rights, MDGs 4 and 5, and now the health-related SDGs, we remain far from changing the conditions in which quality MNH care can be sustainably delivered in Sub-Saharan Africa.

International tracking of State progress increased donor funding to strong performers, but maternal and child mortality remain stubbornly high suggesting that tracking alone has not necessarily improved implementation [70]. Politics at national level often determine resource allocation and there is only modest evidence that increased need or progress translates into greater allocation of national resources for MNH [71]. In fact, evidence of country status or what is happening locally does not necessarily increase political will and resource allocation due to competing priorities, or mismanagement. Ministries of health, providers, and civil society stakeholders do not always agree on the way forward; multiple global and regional strategies for improving progress can add confusion and complicate rather than consolidate efforts. Health system weakness underlies poor performance on international indicators. Nuanced progress and challenges are rarely captured.

4.2. Limitations

This review is limited by the use of the conventional accountability terminology that necessarily limits the scope of the articles included. As a result, articles that focus on formal accountability mechanisms (such as regulations or legal recourse) may not be implemented within a local context to change underlying factors behind the poor quality of care. Without changing power dynamics that underscore how norms are implemented formally or informally in the health sector, we cannot know whether an effect will be seen, directly or indirectly, on the quality of MNH care and outcomes. For example, while facility-based MDRs may identify mortality due to delays in seeking care, they may not, without additional investigation and analysis, uncover provider attitudes and abuse or under-the-table payments as reasons for the delay. People-centered rather than intervention-centered accountability as called for by the independent expert review group of CoIA will help to broaden the definition of accountability and the change expected from such measures.

The review was also limited by excluding nonpeer-reviewed literature. It was further limited in that articles were included that describe accountability mechanisms without attention to the recourse process. Many articles on accountability discuss the importance of calling duty holders to account (in human rights terms), but do not assess the recourse process and its effect. As a result, many articles and reports that discuss accountability including the *Lancet* series on maternal, newborn, and stillbirths, midwifery, and others, as well as the Countdown to 2015 and other global reviews were not included despite playing a significant role in how global, political accountability is commonly understood and appreciated.

5. Conclusion

In a low-resource context as in Sub-Saharan Africa, there are few accountability structures between decision-makers and those affected by those decisions with both the power and the will to enforce answerability. Accountability requires transparency in terms of information on commitments and promises of decision-makers and whether those responsible have acted on them [72]. Performance accountability, reinforced through social and political advocacy, and, where possible, financial accountability such as budget tracking, are most effective when done collectively for common purpose.

Increasing accountability of governments at national and facility level to ensure improvements in the quality of care by providers and managers depends not only on how mechanisms are enforced, but also on how providers and managers understand accountability. Local ideas of (and

advocacy for) accountability for improved care were most successful when they:

- worked through local actors;
- were supported by evidence and grounded in the local context;
- were locally presented, with understandable detail;
- had defined aims for social and political action;
- engaged with multiple stakeholders, each with their respective area of expertise; and
- had locally defined desired outcomes.

Through the political critique of the problems, and collective agreement on solutions, common cause can lead to heightened accountability for MNH.

CoIA commitments and other global tracking of progress against targets assume that when political will is sufficient, progress is tracked and internationally recognized, then accountability will result. However, top-down promotion of "what works" can miss the contextual factors that make progress in one country possible and similar interventions in another less so. As summarized by Freedman and Schaaf [4], the assumed relationship between tallying scores and progress, advocacy to create voice, empowerment or, minimally, awareness and publicity on the tally and accountability within the health system as measured through sustained change, does not necessarily lead to improvement [4]. To achieve improvements in MNH, greater emphasis is needed on the consequences of inaction and who, ultimately, is accountable when health systems do not deliver.

Author contributions

AMH and CB designed and planned the paper; AMH wrote and managed the manuscript; AMH, CB, LFB, SB, EA, and LH contributed sections of the manuscript; AMH, CB, LFB, SB, and EA conducted data analysis and AMH designed the tables.

Acknowledgments

This paper was written in the framework of the Evidence for Action (E4A) program, funded by the UK Government's Department for International Development (DFID). The authors acknowledge the contributions from Luc de Bernis, an independent consultant, and Zoe Matthews from the University of Southampton for their contributions in reviewing the manuscript.

Conflict of interest

All authors except LFP have been supported by the DFID-funded E4A program; AMH as Accountability Lead for the E4A program, CB as Technical Advisor, SB as Lead Technical Advisor, EA as Technical Advisor, and LH as Program Director.

References

[1] Hill M. The Public Policy Process. 4th ed. Essex, England: Pearson Education Limited; 2005.
[2] World Health Organization. Every Woman, Every Child: a post 2015 vision. The third report of the independent Expert Review Group of the Commission on Information and Accountability for Women's and Children's Health. Geneva, Switzerland: WHO; 2014.
[3] Bhutto Z, Chopra M. Viewpoint: Moving ahead: what will a renewed Countdown to 2030 for Women and Children look like? Lancet 2016;387(10032):2060–2.
[4] Freedman LP, Schaaf M. Act global, but think local: accountability at the frontlines. Reprod Health Matters 2013;21(42):103–12.
[5] Brinkerhoff D. Accountability and health systems: towards conceptual clarity and policy relevance. Health Policy Plan 2004;19(6):371–9.
[6] World Bank. Accountability in Governance. http://siteresources.worldbank.org/PUBLICSECTORANDGOVERNANCE/Resources/AccountabilityGovernance.pdf. Published 2016. Accessed September 6, 2016.
[7] Transparency International. The Anti-Corruption Plain Language Guide. http://www.transparency.org/whatwedo/publication/the_anti_corruption_plain_language_guide. Published 2009. Accessed September 6, 2016.
[8] Kerber K, de Graft-Johnson J, Bhutta Z, Okong P, Starrs A, Lawn J. Review; Continuum of care for maternal, newborn, and child health: from slogan to service delivery. Lancet 2007;370(9595):1358–69.
[9] Brinkerhoff D. Taking account of accountability: A conceptual overview and strategic options. Washington DC, USA: U.S. Agency for International Development; 2001.
[10] Brinkerhoff D. Accountability and Health Systems: Overview, Framework, and Strategies. Bethesda, MD, USA: Abt Associates Inc.; 2003.
[11] Cottingham J, Kismodi E, Martin Hilber A, Lincetto O, Stahlhofer M, Gruskin S. Using human rights for sexual and reproductive health: improving legal and regulatory frameworks. Bull World Health Org 2010;88:551–5.
[12] Freedman L. Using human rights in maternal mortality programs: from analysis to strategy. Int J Gynecol Obstet 2001;75(1):51–60.
[13] Countdown Working Group on Health Policy. Countdown to 2015: Trends in RMNCH Financing. New York, NY, USA; 2016.
[14] Kinney MV, Cocoman O, Dickson KE, Daelmans B, Zaka N, Rhoda NR, et al. Implementation of the Every Newborn Action Plan: Progress and lessons learned. Semin Perinatol 2015;39(5):326–37.
[15] Ten Hoope-Bender P, Martin Hilber A, Nove A, Bandali S, Nam S, Armstrong C, et al. Using advocacy and data to strengthen political accountability in maternal and newborn health work in Africa. Int J Gynecol Obstet 2016;135(3):358–64.
[16] Nyamtema AS, Urassa DP, Pembe AB, Kisanga F, van Roosmalen J. Factors for change in maternal and perinatal audit systems in Dar es Salaam hospitals, Tanzania. BMC Pregnancy Childbirth 2010;10:29.
[17] Armstrong CE, Lange IL, Magoma M, Ferla C, Filippi V, Ronsmans C. Strengths and weaknesses in the implementation of maternal and perinatal death reviews in Tanzania: perceptions, processes and practice. Trop Med Int Health 2014;19(9):1087–95.
[18] Mogobe KD, Tshiamo W, Bowelo M. Monitoring maternity mortality in Botswana. Reprod Health Matters 2007;15(30):163–71.
[19] Hofman JJ, Mohammed H. Experiences with facility-based maternal death reviews in northern Nigeria. Int J Gynecol Obstet 2014;126(2):111–4.
[20] Kongnyuy EJ, Leigh B, van den Broek N. Effect of audit and feedback on the availability, utilisation and quality of emergency obstetric care in three districts in Malawi. Women Birth 2008;21(4):149–55.
[21] Vink NM, de Jonge HC, Ter Haar R, Chizimba EM, Stekelenburg J. Maternal death reviews at a rural hospital in Malawi. Int J Gynecol Obstet 2013;120(1):74–7.
[22] Hussein J, D'Ambruoso L, Armar-Klemesu M, Achadi E, Arhinful D, Izati Y, et al. Confidential inquiries into maternal deaths: modifications and adaptations in Ghana and Indonesia. Int J Gynecol Obstet 2009;106(1):80–4.
[23] Issah K, Nang-Beifubah A, Opoku CF. Maternal and neonatal survival and mortality in the Upper West Region of Ghana. Int J Gynecol Obstet 2011;113(3):208–10.
[24] South Africa Every Death Counts Writing Group. Every death counts: use of mortality audit data for decision making to save the lives of mothers, babies, and children in South Africa. Lancet 2008;371(9620):1294–304.
[25] Rhoda NR, Greenfield D, Muller M, Prinsloo R, Pattinson RC, Kauchali S, et al. Experiences with perinatal death reviews in South Africa - The Perinatal Problem Identification Programme: scaling up from programme to province to country. BJOG 2014;121(Suppl. 4):160–6.
[26] Belizan M, Bergh AM, Cilliers C, Pattinson RC, Voce A. Stages of change: A qualitative study on the implementation of a perinatal audit programme in South Africa. BMC Health Serv Res 2011;11:243.
[27] Dumont A, Gaye A, de Bernis L, Chaillet N, Landry A, Delage J, et al. Facility-based maternal death reviews: effects on maternal mortality in a district hospital in Senegal. Bull World Health Organ 2006;84(3):218–24.
[28] Dumont A, Tourigny C, Fournier P. Improving obstetric care in low-resource settings: implementation of facility-based maternal death reviews in five pilot hospitals in Senegal. Hum Resour Health 2009;7:61.
[29] Moshabela M, Sene M, Nanne I, Tankoano Y, Schaefer J, Niang O, et al. Early detection of maternal deaths in Senegal through household-based death notification integrating verbal and social autopsy: a community-level case study. BMC Health Serv Res 2015;15:16.
[30] Bayley O, Chapota H, Kainja E, Phiri T, Gondwe C, King C, et al. Community linked maternal death review (CLMDR) to measure and prevent maternal mortality: a pilot study in rural Malawi. BMJ Open 2015;5(4).
[31] Pirkle CM, Dumont A, Traore M, Zunzunegui MV. Effect of a facility-based multifaceted intervention on the quality of obstetrical care: a cluster randomized controlled trial in Mali and Senegal. BMC Pregnancy Childbirth 2013;13:24.
[32] English M, Nzinga J, Mbindyo P, Ayieko P, Irimu G, Mbaabu L. Explaining the effects of a multifaceted intervention to improve inpatient care in rural Kenyan hospitals–interpretation based on retrospective examination of data from participant observation, quantitative and qualitative studies. Implement Sci 2011;6:124.
[33] Beyeza-Kashesya J, Kaharuza F, Murokora D. The advantage of professional organizations as advocates for improved funding of maternal and child health services in Uganda. Int J Gynecol Obstet 2014;127(Suppl. 1):S52–5.
[34] De Brouwere V, Delvaux T, Leke RJ. Achievements and lessons learnt from facility-based maternal death reviews in Cameroon. BJOG 2014;121(Suppl. 4):71–4.
[35] Gebrehiwot Y, Tewolde BT. Improving maternity care in Ethiopia through facility based review of maternal deaths and near misses. Int J Gynecol Obstet 2014;127(Suppl. 1):S29–34.
[36] Crofts J, Moyo J, Ndebele W, Mhlanga S, Draycott T, Sibanda T. Adaptation and implementation of local maternity dashboards in a Zimbabwean hospital to drive clinical improvement. Bull World Health Organ 2014;92(2):146–52.
[37] Yilla M, Nam SL, Adeyemo A, Kargbo SA. Using scorecards to achieve facility improvements for maternal and newborn health. Int J Gynecol Obstet 2014;127(1):108–12.
[38] Ray S, Madzimbamuto F, Fonn S. Activism: working to reduce maternal mortality through civil society and health professional alliances in sub-Saharan Africa. Reprod Health Matters 2012;20(39):40–9.

[39] Mafuta EM, Dieleman MA, Hogema LM, Khomba PN, Zioko FM, Kayembe PK, et al. Social accountability for maternal health services in Muanda and Bolenge Health Zones, Democratic Republic of Congo: a situation analysis. BMC Health Serv Res 2015;15:514.
[40] O'Meara WP, Tsofa B, Molyneux S, Goodman C, McKenzie FE. Community and facility-level engagement in planning and budgeting for the government health sector– a district perspective from Kenya. Health Policy 2011;99(3):234–43.
[41] Center for Reproductive Rights and Federation of Women Lawyers - Kenya. Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities. http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bo_failuretodeliver.pdf. Published 2007. Accessed September 6, 2016.
[42] Garba AM, Bandali S. The Nigeria Independent Accountability Mechanism for maternal, newborn, and child health. Int J Gynecol Obstet 2014;127(1):113–6.
[43] Balogun V, Durojaye E. The African Commission on Human and Peoples' Rights and the promotion and protection of sexual and reproductive rights. Afr Hum Rights Law J 2011;11(2):368–95.
[44] Minister of Health v TAC Hearing before the Constitutional Court of South Africa; 2001.
[45] de Bernis L, Shoo R. Maternal death review in Africa. Int J Gynecol Obstet 2009; 106(1):89–94.
[46] Jones R, Slade P, Pascalis O, Herbert JS. Infant interest in their mother's face is associated with maternal psychological health. Infant Behav Dev 2013;36(4):686–93.
[47] Mhango C, Mvula L, Sander G, Lee JY, Hunt P. Children's health in Malawi. In: Bustreo F, Hunt P, editors. Women's and children's health: evidence of impact of human rights. Geneva, Switzerland: WHO; 2013. p. 42–51.
[48] Powell-Jackson T, Borghi J, Mueller DH, Patouillard E, Mills A. Countdown to 2015: tracking donor assistance to maternal, newborn, and child health. Lancet 2006; 368(9541):1077–87.
[49] Sidze EM, Pradhan J, Beekink E, Maina TM, Maina BW. Reproductive health financing in Kenya: an analysis of national commitments, donor assistance, and the resources tracking process. Reprod Health Matters 2013;21(42):139–50.
[50] Mbeeli T, Samahiya M, Ravishankar N, Zere E, Kirigia JM. Resource flows for health care: Namibia reproductive health sub-accounts. Int Arch Med 2011;4(1):1–9.
[51] Basinga P, Gertler P, Binagwaho A, Soucat ALB, Sturdy J, Vermeersch CM. Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: an impact evaluation. Lancet 2011;377:1421–8.
[52] Bellows BW, Conlon CM, Higgs ES, Townsend JW, Nahed MG, Cavanaugh K, et al. A Taxonomy and Results from a Comprehensive Review of 28 Maternal Health Voucher Programmes. J Health Popul Nutr 2013;31(4):106–28.
[53] Harding A, Preker A, editors. Private Participation in Health Services; 2003 Washington, DC, USA.
[54] Bank. W. Reducing Maternal Mortality, Strengthening the World Bank Response, Washington DC, USA; 2009.
[55] Rwanda Ministry of Health. Success Factors for Women's and Children's Health: Rwanda. Geneva, Switzerland; 2014.
[56] Chamberlain J, McDonagh R, Lalonde A, Arulkumaran S. The role of professional associations in reducing maternal mortality worldwide. Int J Gynecol Obstet 2003; 83(1):94–102.
[57] World Health Organization. Keeping Promises, Measuring Results: Commission on Information and Accountability for Women's and Children's Health. Geneva, Switzerland; 2011.
[58] CSDH. Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Geneva, Switzerland; 2008.
[59] Agarwal S, Heltberg R, Diachok M. Scaling-up Social Accountability in World Bank Operations. Washington, DC, USA; 2009.
[60] Gilmore K, Mora L, Barragues A, Krogh Mikkelsen I. The Universal Periodic Review: A Platform for Dialogue, Accountability, and Change on Sexual and Reproductive Health and Rights. Health Hum Rights 2015;17(2).
[61] World Health Organization. Every Women Every Child 2015. Geneva, Switzerland 2016. http://globalstrategy.everywomaneverychild.org/. Published 2015. Accessed September 6, 2016.
[62] Bredenkamp C, Fritsche GB, Meessen B, Ndizeye C, Soeters RA, Heteren GV. Performance-based financing toolkit. Washington, DC, USA; 2014.
[63] The AIDSTAR-Two Project. The PBF Handbook: Designing and Implementing Effective Performance-Based Financing Programs. Cambridge, MA, USA; 2011.
[64] Oxman A, Fretheim A. Can paying for results help to achieve the Millennium Development Goals? Overview of the effectiveness of results-based financing. J Evid Based Med 2009;2:70–83.
[65] Meessen B, Soucat A, Sekabaraga C. Performance-based financing: just a donor fad or a catalyst towards comprehensive health-care reform? Bull World Health Organ 2011;89:153–6.
[66] Ireland M, Paul M, Dujardin B. Can performance-based financing be used to reform health systems in developing countries? Bull World Health Organ 2011;89(9): 695–8.
[67] Sipsma HL, Curry LA, Kakoma J-B, Linnander EL, Bradley EH. Identifying characteristics associated with performing recommended practices in maternal and newborn care among health facilities in Rwanda: a cross-sectional study. Hum Resour Health 2012;10.
[68] Easterly W. How the Millennium Development Goals are Unfair to Africa. World Dev 2009;37(1):26–35.
[69] Clemens MA, Kenny CJ, Moss TJ. The Trouble with the MDGs: Confronting Expectations of Aid and Development Success. World Dev 2007;35(5):735–51.
[70] Wild L, Domingo P. Accountability and Aid in the Health Sector. https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/6188.pdf. Published 2010. Accessed September 6, 2016.
[71] Rocha Menocal A, Sharma B. Joint evaluation of citizens' voice and accountability: synthesis report. https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/3425.pdf. Published 2008. Accessed September 6, 2016.
[72] Gaventa J, McGee R. The impact of transparency and accountability initiatives. Dev Policy Rev 2013;31(s1):s3–s28.